



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

NORTH GARLAND SURGERY CENTER

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-15-3176-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MAY 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was processed incorrectly and underpaid."

Amount in Dispute: \$13,869.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. This is a fee schedule adjustment. \$19,053.19 has been paid."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 10, 2015	Ambulatory Surgical Care for CPT Code 63685	\$13,869.85	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is the requestor entitled to additional reimbursement for code 63685?

Findings

28 Texas Administrative Code §134.402(d) states “ For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.”

CPT code 63685 is defined as “Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling.”

According to Addendum AA, CPT code 63685 is a device intensive procedure.

28 Texas Administrative Code §134.402(f)(2) states “Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent; or (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent.”

To determine the MAR for code 63685 is a five-step process:

1. Step 1-Gather factors:

- According to Addendum B found on CMS website, the hospital outpatient prospective payment amount for code 63685 is \$26,162.39.
- The device dependent APC offset percentage found in Table 48 for National Hospital OPPS for code 63685 for CY 2015 is 87%.
- According to Addendum AA found on CMS website, CPT code 63685 has a Medicare fully implemented ASC reimbursement of \$20,813.64.
- The Core Based Statistical Area (CBSA-City Wage Index) located on the White House/OMB website or CMS website for Garland, Texas is 0.9703.

2. Step 2- To determine the device portion, you multiply the hospital outpatient prospective payment amount times the device dependent APC offset percentage:

$\$26,162.39 \text{ multiplied by } 87\% = \$22,761.27.$

3. Step 3 - Find the geographically adjusted Medicare ASC reimbursement for code 63685. This step requires calculations:

- The Medicare fully implemented ASC reimbursement rate of \$20,813.64 is divided by 2 = \$10,406.82.
- This number multiplied by the City Wage Index for Garland, TX $\$10,406.82 \times 0.9703 = \$10,097.73.$
- The sum of these two is the geographically adjusted Medicare ASC reimbursement = \$20,504.55.

4. Step 4- To determine the service portion:

- Subtract the device portion from the geographically adjusted Medicare ASC reimbursement
 $\$20,504.55 \text{ minus } \$22,761.27 = -\$2,256.72.$
- Multiply the service portion by the DWC payment adjustment factor of 235%
 $-\$2,256.72 \text{ multiplied by } 235\% = -\$5,303.29$

5. Step 5-Add the service and device portion together to determine MAR.

$-\$5,303.29 + \$22,761.27 = \$17,457.98.$

The respondent paid \$19,053.19. As a result, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	<u>07/14/2015</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.